CHAPTER He-W 500 MEDICAL ASSISTANCE

PART He-W 506 MEDICAID CARE MANAGEMENT (MCM)

Readopt with amendment He-W 506.02, effective 9/13/13 (Document #10410), to read as follows:

He-W 506.02 Scope. This part shall apply to all medicaid recipients insofar as they are required to enroll in managed care. Those recipients who are not enrolled in managed care shall receive medicaid services on a fee-for-service basis in accordance with applicable rules in He-W 500.

Amend He-W 506.03, effective 9/13/13 (Document #10410), as amended effective 7/1/14 (Document #10631), by amending paragraph (d) and by deleting paragraph (i) and renumbering subsequent paragraphs, so that He-W 506.03(d) and (i) are cited and read as follows:

He-W 506.03 Definitions.

(d) "Enrollee" means a recipient who is enrolled in managed care and who has not yet selected an MCO.

Readopt with amendment He-W 506.05, effective 7/1/14 (Document #10631), to read as follows:

He-W 506.05 Enrollment in Managed Care.

(a) Enrollment in managed care shall be mandatory for all individuals who are eligible for medicaid through the NHHPP.

(b) All other medicaid recipients shall be enrolled in managed care unless the recipient is excluded from managed care as described in (c) below.

(c) The following individuals shall not be allowed to enroll in managed care:

(1) Recipients receiving benefits from the U.S. Department of Veterans Affairs;

(2) Recipients receiving in and out medically needy assistance in accordance with 42 CFR 435.301 and He-W 678.01; and

(3) Individuals who have qualified medicare beneficiary/specified low-income medicare beneficiary (QMB/SLMB) benefits only, and are not eligible for medicaid service coverage.

(d) Any recipient not enrolled in managed care shall receive medicaid services on a fee-for-service basis.

Readopt with amendment He-W 506.06, effective 9/13/13 (Document #10410), to read as follows:

He-W 506.06 Selection of a Managed Care Organization.

(a) The department shall send a notice of managed care enrollment and MCO selection to all recipients not excluded from managed care per He-W 506.05(c).

(b) Recipients shall have 30 days from the date of the notice in (a) above select an MCO by responding to the department, via writing, telephone, or by utilizing the on-line NH Electronic Application System (NH EASY).

(c) If a recipient fails to select an MCO as required by (b) above, an MCO shall be auto-assigned to the recipient.

(d) Auto-assignments shall be based on the following criteria:

(1) MCO participation of a primary care provider with whom the enrollee has a pre-existing relationship as demonstrated by past claims history;

(2) MCO participation of a specialty care provider with whom the enrollee has a pre-existing relationship as demonstrated by past claims history;

(3) MCO selection by a household family member of the enrollee;

(4) MCO previously selected prior to a loss of medicaid eligibility; or

(5) If no assignment can be made utilizing (1)-(4) above, assignment shall be based on an algorithm, which has been contractually agreed to by the department and the MCO, that ensures equitable enrollment of enrollees across all MCOs.

(e) A member may request to change his or her MCO selection without cause, by making a written or oral request to the department at any of the following times:

(1) During the 90 days following the date of the member's initial selection of or the auto-assignment to the MCO, or the date the department sends the member confirmation of the member's selection or auto-assignment, whichever is later;

(2) At any time for members who are auto-assigned to the MCO and who have an established relationship with a primary care provider that is only in the network of a non-assigned MCO;

(3) During annual open enrollment periods;

(4) For 60 days following an automatic re-enrollment if the temporary loss of medicaid eligibility causes the member to miss the annual re-enrollment/disenrollment opportunity. This provision shall apply to redeterminations only and shall not apply when an individual is completing a new application for medicaid eligibility; and

(5) When the department imposes an intermediate sanction specified in 42 CFR 438.702(a)(3).

(f) A member may request to change his or her MCO selection with cause, by making a written or oral request to the department at any time for any of the following reasons:

(1) The member requires related services simultaneously that are not available in the MCO's network and bifurcation of the care creates unnecessary risk to the member as determined by the member's treating provider;

(2) The member wants to select the same managed care plan as a household family member;

(3) Poor quality of care;

(4) Lack of access to covered services;

(5) The member has experienced a violation of his or her member rights, as established in 42 CFR 438.100; or

(6) The MCO's network providers are not experienced in the member's unique healthcare needs.

(g) If a request made pursuant to (e) or (f) above does not include the selection of a different MCO, the department shall not act on the request unless there are only 2 MCOs.

(h) A member may request a department fair hearing of a denial of (e) or (f) above in accordance with He-C 200 without first exhausting the MCO appeal process.

(i) A member shall be locked into the selected or auto-assigned MCO for a period of 12 months or until the next open enrollment period, whichever comes first, unless the member changes his or her MCO selection in accordance with (e)(1), (2), (5), or (f) above.

(j) A member shall disenroll from an MCO when the member has moved out of state and is no longer NH medicaid eligible.

(k) An MCO may request the department to disenroll a member who is threatening or abusive such that the health or safety of other members, MCO staff, or providers is jeopardized.

(l) The department shall approve a request for disenrollment in (k) above when no other option is available that would ensure the health and safety of other members, MCO staff, or providers.

(m) If the department approves an MCO request for involuntary disenrollment, the member may request a department fair hearing of the disenrollment in accordance with He-C 200 without first exhausting the MCO appeal process.

(n) Members appealing involuntary disenrollment may request a continuation of services pending appeal as outlined in 42 CFR 431.230.

APPENDIX B

RULE	STATE OR FEDERAL STATUTE THE RULE IMPLEMENTS
He-W 506.02	RSA 126-A:5, XIX; §1932(a) of the SSA; 42 U.S.C. 1396u-2
He-W 506.03(d) & (i)[deleted]	§1932(a) of the SSA; 42 CFR 438.2; 42 U.S.C. 1396u-2
He-W 506.05	§1932(a)(4) of the SSA; §1915(b)1 of the SSA; §1915(b)(4) of the SSA; 42 CFR 438.56 and .226
He-W 506.06	§1932(a)(4) of the SSA; 42 CFR 438.52; 42 CFR 438.700